

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09642

9649

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Worchester</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Worchester #1</i>		c. LENGTH OF STAY IN 1b <i>30 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Worchester #1</i>	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Alice</i>	Middle <i>B.</i>	Last <i>Bradford</i>
4. DATE OF DEATH	Month <i>Aug.</i>	Day <i>16</i>	Year <i>1958</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 19/1875</i>
9. AGE (In years lost birthday) <i>83 1/2 yrs</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	11. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	12. BIRTHPLACE (State or foreign country) <i>Worchester, MD</i>
13. FATHER'S NAME <i>William H. Holston</i>	14. MOTHER'S MAIDEN NAME <i>Hester Payne</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>215-38-1872</i>	17. INFORMANT <i>Mary J. Russell Bradford, Worchester, MD</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CEREBRAL VASCULAR ACCIDENT</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <i>4443X</i>		INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i>	
(b) <i>HYPERTENSIVE CARDIO VASCULAR DISEASE</i>		10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>JUNE</i> , 19 <i>52</i> , to <i>AVG. 16</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>AVG. 15</i> , 19 <i>58</i> , and that death occurred at <i>10 P</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>Joseph La Mar</i>	M.D. <i>Ray St., Snow Hill, Md.</i> 8-18-58		
PHYSICIAN'S NAME (Type) <i>Robert C. La Mar, M. D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Aug. 19/58</i>	22b. DATE THEREOF <i>Aug. 19/58</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Township Cemetery, Worchester</i>	22d. LOCATION (City, town, or county) <i>Worchester</i> (State) <i>MD</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Clay & Sonni</i>	ADDRESS <i>Snow Hill, Md.</i>	24a. REC'D BY REGISTRAR DATE <i>AUG 19 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbons. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

11-12-18

11-12-18

11-12-18

11-12-18

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9650

CERTIFICATE OF DEATH

09643

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md		b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN		c. LENGTH OF STAY IN 1b 1521N		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN		d. STREET ADDRESS "PARROTOWN"			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS "PARROTOWN"		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) SALLIE MASSEY		First BRITTINGHAM	Middle 	Lost 	4. DATE OF DEATH AUG- 7 1958	Month AUG	Day 7	Year 1958	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 24, 1861		9. AGE (In years lost birthday) 97 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) BERLIN, MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME COENGLIUS WIDAGON		14. MOTHER'S MAIDEN NAME HETTY PHILLIPS							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Mr. Harry MASSEY		Address BERLIN, MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592x		DUE TO Chronic Brights				INTERVAL BETWEEN ONSET AND DEATH 2 mo			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO Chr Nephritis with oedema							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Berlin Md.		(County) 	(State)
21. I certify that I attended the deceased from June 10 - 1958 to July 7 - 1958 , that I last saw the deceased alive on July 6 - 1958 , and that death occurred at 4:20 AM , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Berlin Md.		DATE SIGNED Aug 7 - 1958	
ACTUAL SIGNATURE Chas. R. Law									
PHYSICIAN'S NAME (Type) 									
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/10/58		22c. NAME OF CEMETERY OR CREMATORIAL WICOMICO MEMORIAL		22d. LOCATION (City, town, or county) Salisbury - MD		(State) 	
23. FUNERAL DIRECTOR'S SIGNATURE Anna A. Bubba Berlin Md.		ADDRESS 		24a. REC'D BY REGISTRAR DATE AUG 11 '58		24b. REGISTRAR'S SIGNATURE W. L. L. L.			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9651

CERTIFICATE OF DEATH

09644

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Worcester</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MD</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>/</i>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First <i>Rhoda</i>	Middle <i>E. Carmean</i>	Last 4. DATE OF DEATH <i>Aug. 21 1958</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <i>Feb 14 1884</i>	9. AGE (In years last birthday) <i>74 6/7 yrs.</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Bun Home</i>	11. BIRTHPLACE (State or foreign country) <i>Frankford, Del.</i>			
13. FATHER'S NAME <i>Sidney Lewis</i>		14. MOTHER'S MAIDEN NAME <i>Sally Mary Niblett</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>213-01-7537</i>	17. INFORMANT Address <i>Mrs. Dan L. Carmean, Snow Hill, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>443X</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>HYPERTENSIVE CARDIOVASCULAR DISEASE</i>		DUE TO <i>ACUTE PULMONARY EDEMA</i>				
DUE TO <i>CACHEXIA AND INANITION</i>		(c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>CACHEXIA AND INANITION</i>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. p.m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Bay St., Snow Hill, Md.</i>	(County) <i></i>	(State) <i></i>
21. I certify that I attended the deceased from <i>1948</i> , 19, to <i>Aug 21, 1958</i> , that I last saw the deceased alive on <i>AUGUST 20, 1958</i> , and that death occurred at <i>5:00 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Robert C. La Mar</i> M.D. PHYSICIAN'S NAME (Type) <i>Robert C. La Mar</i>						
22d. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Aug. 24/58</i>		22b. DATE THEREOF <i>Aug. 24/58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Bates Cemetery</i>	22d. LOCATION (City, town, or county) <i>Snow Hill</i>	(State) <i>MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Elmer S. Minis</i>		ADDRESS <i>Snow Hill, Md.</i>	24a. REC'D BY REGISTRAR DATE <i>AUG 25 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Elmer S. Minis</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove card. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9652

CERTIFICATE OF DEATH

Reg. Dist. No.

09645

1. PLACE OF DEATH a. COUNTY <i>Mercato</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Mercato</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill Rural #1</i>		c. LENGTH OF STAY IN 1b <i>2 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i> <i>Rural #1</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Daisy</i>	Middle <i>B.</i>	Last <i>Cheeser</i>	4. DATE OF DEATH Month <i>Aug.</i>	Day Year <i>12 1958</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 15-1893</i>	9. AGE (in years, last birthday) <i>65 1/2 yr.</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>6</i> Days <i>12</i> Hours <i>0</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>		11. BIRTHPLACE (State or foreign country) <i>Newark, Md</i>	
13. FATHER'S NAME <i>John B. Bradford</i>		14. MOTHER'S MAIDEN NAME <i>Mary Jackson</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>213-14-6442</i>		17. INFORMANT <i>ms Fred C. Wells Snow Hill, Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>UREMIA</i>		DUE TO <i>446 X</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 wks</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>RENAL SCLEROSIS</i>		(b) <i>RENAL SCLEROSIS</i>		10 YRS	
(c) <i>GENERALIZED HYPERTENSIVE DISEASE</i>				10 YRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>JUNE</i> , 19 <i>58</i> , to <i>Aug 12</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>Aug 12</i> , 19 <i>58</i> , and that death occurred at <i>11:30 P.M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>Robert C. LaMar</i> M.D. <i>104 Bay Street</i> <i>8-13-58</i>					
PHYSICIAN'S NAME (Type) <i>Robert C. LaMar, M.D.</i>		Snow Hill, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Aug 15 1958</i>		22b. DATE THEREOF <i>June 13 1958</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Grace Baptist Cemetery</i>	
22d. LOCATION (City, town, or county) <i>Snow Hill</i>				(State) <i>MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Clay B. Morris</i>		ADDRESS <i>Snow Hill, Md</i>		24c. REC'D. BY REGISTRAR DATE <i>AUG 14 '58</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be used as the burial-transit Permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial or removal, or removal, and in any event within 72 hours after death.

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9648 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09646

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: See 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)	
Worcester		a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Accomack Co. Md.		35 minutes	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS	
d. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First: Dennis Middle: May Last: Dunn		Month: 8	Day: 7
5. SEX		6. COLOR OR RACE	
2		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Sept 22 1957	
9. AGE (In years last birthday)		10. IF UNDER 1 YEAR yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
10c. Father's Name		11. BIRTHPLACE (State or foreign country)	
John Dunn		Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY?		13. MOTHER'S MAIDEN NAME	
U.S.A.		Augustine Dragon	
14. MOTHER'S MAIDEN NAME		Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
(If yes, give war or dates of service)		17. INFORMANT	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		19. INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		2 days	
493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		22. BURIAL, CREMATION REMOVAL (Specify)	
ACTUAL SIGNATURE Dr. John Dunn		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED 8/7/58	
22b. DATE THEREOF 8/8/58		22c. NAME OF CEMETERY OR CREMATORIAL R. B. White Memorial Parksville, VA	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar Wharton New Church, VA		24a. REC'D BY REGISTRAR 11/11/58	
ADDRESS		24b. REGISTRAR'S SIGNATURE DeLoach	

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09647

9653

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
<i>Dorchester</i> MARYLAND		Texas b. COUNTY (7)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Georgetown (Rural)</i>		802-2 (7)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS (7)	
3. NAME OF DECEASED (Type or print)		First <i>George</i>	Middle <i>Edwards</i>
4. DATE OF DEATH		Month 8	Day 20
5. SEX		Last Dont Know	Year 1958
6. COLOR OR RACE		9. AGE (In years last birthday) 72 yrs.	10. IF UNDER 1 YEAR Months Days
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BIRTHPLACE (State or foreign country) D. K.	12. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) <i>Laborer</i>		12. CITIZEN OF WHAT COUNTRY? <i>Foreign</i> U.S.A.	
13. FATHER'S NAME D. K.		14. MOTHER'S MAIDEN NAME D. K.	
15. HAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No, print or initial) <i>DK</i>		16. SOCIAL SECURITY NO. <i>DK</i> 17. INFORMANT Address <i>A 2 weeks acquaintance</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>783.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>Hemorrhage of lungs sudden</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Too heavy work for an old man with long disease</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>DK</i>	
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year T9	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		ACTUAL SIGNATURE <i>T.R. Sartorius Jr.</i> DATE SIGNED EXAMINER'S NAME (Type) <i>N.F. Sartorius Jr.</i> 8/20/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8/20/58</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Green Hill Cemetery</i>
22d. LOCATION (City, town, or county) <i>Green Hill, Maryland</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edgar - reharts New Church</i>		ADDRESS <i>1014</i>	24a. REC'D BY REGISTRAR DATE AUG 27 '58
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial; cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09648

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WORCESTER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN		b. COUNTY WORCESTER	
c. LENGTH OF STAY IN 1b 3 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS R.F.D. # 2	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First IVAN	Middle G	Last GNIDENKO
4. DATE OF DEATH	Month AUG	Day 5	Year 1958
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH OCT 25 1897
9. AGE (In years last birthday) 60 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BROILER KAISER	11. KIND OF BUSINESS OR INDUSTRY FARM WORK	12. BIRTHPLACE (State or foreign country) SHWATO, HUSKI, UKRAINE
13. FATHER'S NAME STEPHEN GNIDENKO	14. MOTHER'S MAIDEN NAME MARATHA NEDESTUPKA		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 192-26-7944	17. INFORMANT MRS IVAN GNIDENKO, BERLIN MD	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conanary Thrombosis , DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost.			
INTERVAL BETWEEN ONSET AND DEATH minutes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE Herman A. Robbins		DATE SIGNED 8/7/58	
EXAMINER'S NAME (Type) HERMAN A. ROBBINS		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	22b. DATE THEREOF 8/9/58	22c. NAME OF CEMETERY OR CREMATORIUM EVERGREEN	22d. LOCATION (City, town, or county) (State) BERLIN MD
23. FUNERAL DIRECTOR'S SIGNATURE Arthur A. Fairbairn Berlin Md		24a. REC'D BY REGISTRAR DATE AUG 12 1958	
		24b. REGISTRAR'S SIGNATURE Arthur A. Fairbairn	

THE SEVEN AXES OF INFLUENCE OF THE STATE OF SOUTH AFRICA

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9655

CERTIFICATE OF DEATH

Reg. Dist. No.

09649

1. PLACE OF DEATH a. COUNTY WORCESTER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN		c. LENGTH OF STAY IN 1b 61 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN	
3. NAME OF DECEASED (Type or print) LAMBERT Ayres HASTINGS		d. STREET ADDRESS 1 Bay St	
4. SEX M		5. COLOR OR RACE W	
6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		7. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH AUG. 22, 1896		9. AGE (in years from birthdate) 61 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BROILER RAISER		10b. KIND OF BUSINESS OR INDUSTRY CHICKEN FARM	
11. BIRTHPLACE (State or foreign country) BERLIN MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LAMBERT A. HASTINGS		14. MOTHER'S MAIDEN NAME SARAH FISHER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-22-8811	
17. INFORMANT Mrs. L.A. HASTINGS		Address BERLIN MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 467.0		DUE TO Carotary occlusion	
Conditions, if any, which gave rise to immediate cause (o), stoning the underlying cause lost. (b) DUE TO " (c) Hypotension "		INTERVAL BETWEEN ONSET AND DEATH 1 hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Berlin (County) MD (State)	
21. I certify that I attended the deceased from June 1957 to August 9, 1958 , that I last saw the deceased alive on Aug. 9, 1958 , and that death occurred at 11:15 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE ROBERT A. GRUBB, M.D.		ADDRESS (Street, city or town, state) Berlin, Md.	
PHYSICIAN'S NAME (Type) ROBERT A. GRUBB, M.D.		DATE SIGNED 8/12/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF AUG. 12, 1958	
22c. NAME OF CEMETERY OR CREMATORIAL PARSONS		22d. LOCATION (City, town, or county) PITTSVILLE (State) MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Doris R. Bubye Berlin Md.		ADDRESS Doris R. Bubye Berlin Md.	
24a. REC'D. BY REGISTRAR AUG 15 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Thorne	

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1 X
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1-2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PN3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1-2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9656 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09650

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ocean City		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 25 (Brooklyn Park)		d. STREET ADDRESS 249 Meadow Rd. 0250.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Beach, North 6th St.				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First JOSEPH	Middle EARL	Last HAUHN, JR.	4. DATE OF DEATH August 18, 1958	Month August	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 6, 1925	9. AGE (In years last birthday) 33 yrs.	10. KIND OF BUSINESS OR INDUSTRY Store Goodyear Tire Co.	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	12. CITIZEN OF WHAT COUNTRY? USA
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Executive							
13. FATHER'S NAME J.E. Hauhn, Sr.		14. MOTHER'S MAIDEN NAME Jennie V. Korythowski		15. WAS DECEASED EVER IN U. S. ARMED FORCES? no		16. SOCIAL SECURITY NO. 212-20-3256 17. INFORMANT Mrs. Eva Hauhn	
						Address Baltimore 25, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 929.8 Drowning DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Drowned while swimming		20c. TIME OF INJURY Month, Day, Year Hour o.m. XDX 8/18/58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> water	
				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Ocean City		20f. (City or town) Worcester Md.	(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 8/19/58	
ACTUAL SIGNATURE <i>William V. Lovitt</i>		EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.		22b. DATE THEREOF REMOVAL (Specify) BURIAL Aug 22, 1958		22c. NAME OF CEMETERY OR CREMATORY GLEN HAVEN MEMPK.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22d. LOCATION (City, town, or county) (State) GLEN BURNIE Md.		22d. LOCATION (City, town, or county) (State) GLEN BURNIE Md.		24a. REC'D BY REGISTRAR DATE AUG 22 '58	
23. FUNERAL DIRECTOR'S SIGNATURE <i>George J. Jones</i>		ADDRESS 4001 RITCHIE Hwy.				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

WICHIGAN EXCAVATOR COMPANY, 3

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09651

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Worcester</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <i>Del.</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton, Del., 19605</i>		c. LENGTH OF STAY IN 1b <i>5 days</i>				
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ocean City, Md.</i>		d. STREET ADDRESS <i>Oak Orchard Road</i>				
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <i>Easton Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>George A. Hodges</i>		First <i>M.</i>	Middle <i>W.</i>			
4. DATE OF DEATH <i>Aug 29 1958</i>		Last <i>13</i>	Month <i>Aug</i>			
5. SEX <i>M.</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <i>Divorced</i>			
8. DATE OF BIRTH <i>Jul 13-1891</i>		9. AGE (In years last birthday) <i>67 yrs</i>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Passenger carrier, bus driver</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Passenger carrier, bus driver</i>				
11. BIRTHPLACE (State or foreign country) <i>Philadelphia U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				
13. FATHER'S NAME <i>Wm. J. Hodges</i>		14. MOTHER'S MAIDEN NAME <i>Adeline Bressert</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>123-45-6789</i>				
17. INFORMANT <i>Mrs. George Hodges</i>		Address <i>12345 Cedar</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stealing the underlying cause last. (b) DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Coronary occlusion, faintly</i>						
20c. TIME OF INJURY Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <i>Not while at work</i>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	20f. (City or town) <i>Philadelphia</i>	(County) <i>Philadelphia</i>	(State) <i>Pa.</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> <i>N. E. Sartorius Sr.</i>						
ACTUAL SIGNATURE <i>N. E. Sartorius Sr.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9/3/58</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Oakland Cemetery</i>	22d. LOCATION (City, town, or county) <i>Philadelphia</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Anna A. Bubay</i>		ADDRESS <i>Berlin Md</i>	24a. REG'D BY REGISTRAR DATE <i>SEP 3 '58</i>	24b. REGISTRAR'S SIGNATURE <i>John S. Haas</i>		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03652

9658

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Worcester</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Berlin</i>		c. LENGTH OF STAY IN 1b <i>2 Months</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Route 2 Berlin</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. STREET ADDRESS <i>1414 Bolton St</i>		d. STREET ADDRESS <i>3701-4</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>LOUIS Reed</i>		First <i>LOUIS</i>	Middle <i>Reed</i>
4. DATE OF DEATH <i>August 24</i>		Last <i>Huppman</i>	Month Year <i>1958</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 13, 1902</i>
9. AGE (In years last birthday) <i>55</i>	10. IF UNDER 1 YEAR Months <i>5</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
13. FATHER'S NAME <i>Nicholas Maynard Huppman</i>	14. MOTHER'S MAIDEN NAME <i>Mary Elizabeth Bigham</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>28 12 6577</i>	17. INFORMANT <i>Mrs Louis Huppman</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Rheumatic Heart Disease</i>	
DUE TO <i>416X</i>		INTERVAL BETWEEN ONSET AND DEATH <i>15 years</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. p. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>June 1958</i> to <i>Aug 24, 1958</i> that I last saw the deceased alive on <i>Aug 24, 1958</i> , and that death occurred at <i>12 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Ocean City Md.</i> DATE SIGNED <i>Aug 25, 1958.</i>			
ACTUAL SIGNATURE <i>Francis J. Townsend Jr.</i>		PHYSICIAN'S NAME (Type) <i>Francis J. Townsend Jr.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	22b. DATE THEREOF <i>8/26/58</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Green Mount</i>	22d. LOCATION (City, town, or county) <i>Ocean City Md.</i> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Elephant</i>	ADDRESS <i>1000 N. Wolfe St. York</i>	24a. REC'D BY REGISTRAR DATE <i>Aug 27 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur E. Thrasher</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: If this certificate has been signed by the attending physician or by the funeral director, Page 3 should be detached and use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09653

9659

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WORCESTER		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD		b. COUNTY WORCESTER		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SITOWELL		c. LENGTH OF STAY IN lb 25 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X BHOWGULLS		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Ocea	Middle EMMA	Last LEWIS	4. DATE OF DEATH AUG. 28 1958	Month AUG.	Day 28	Year 1958
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 3, 1874	9. AGE (In years lost birthday) 84 yrs.	IF UNDER 1 YEAR Months 8	IF UNDER 24 HRS. Days 4	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) POWELLVILLE MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME CHARLES COLLINS		14. MOTHER'S MAIDEN NAME ANDY LEWIS						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT MR. RAY LEWIS, SHONWELL MD.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		b. Acute Congestive Cardiac failure		c. Hypertension		INTERVAL BETWEEN ONSET AND DEATH 1-2 hours 10-15 yrs.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) artero sclerosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) fall						
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Doy Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) BERLIN, MD.	20f. (City or town) BERLIN	(County) BERLIN	(State) MD	
21. I certify that I attended the deceased from November 1953 to August 1958 that I last saw the deceased alive on August 28, 1958 , and that death occurred at BERLIN, MD. from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>Robert A. Grubb</i>	M.D.		ADDRESS (Street, city or town, state) BERLIN, MD.		DATE SIGNED 8/30/58			
PHYSICIAN'S NAME (Type) ROBERT A. GRUBB M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF Aug. 31, 1958	22c. NAME OF CEMETERY OR CREMATORIAL EVERGREEN	22d. LOCATION (City, town, or county) BERLIN	(State) MD				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Anna A. Burbage</i>	ADDRESS Berlin, MD.	24a. REC'D BY REGISTRAR DATE SEP 3 '58	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: Fill in this certificate has been signed by the attending physician or by the funeral director. Then please remove carb. papers. Pages 1 and 2 should be filed with the registrar prior to burial.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9660

CERTIFICATE OF DEATH

Reg. Dist. No.

09654

1. PLACE OF DEATH a. COUNTY <i>Marinette</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Marinette</i>		c. LENGTH OF STAY IN 1b <i>6 days</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MD</i>		b. COUNTY <i>Marinette</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>None</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Newark</i>		d. STREET ADDRESS <i>None</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print)	First <i>Homer</i>	Middle <i></i>	Last <i>Schaffield</i>	4. DATE OF DEATH Month <i>Aug</i>	Day <i>18</i>	Year <i>1958</i>
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5. SEX <i>Male</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec 19-1889</i>	9. AGE (In years last birthday) <i>68 7/29</i>	IF UNDER 1 YEAR Months <i></i>	IF UNDER 24 HRS. Days <i></i>	Hours <i></i>	Min. <i></i>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Clerical</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Dept Co. Wild Newark, MD</i>	11. BIRTHPLACE (State or foreign country) <i>Newark, MD</i>	12. CITIZEN OF WHAT COUNTRY? <i></i>
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13. FATHER'S NAME <i>Isaac Schaffield</i>	14. MOTHER'S MAIDEN NAME <i>McKeevy</i>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Mr. Gutted Schaffield, Newark, MD</i>	Address <i></i>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocarditis</i>		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <i>Hypertension-</i>		
(b) DUE TO <i>Epilepsy - Gangrenous feet</i>		
(c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>				
20c. TIME OF INJURY Hour a. p. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) <i></i>	(County) <i></i>	(State) <i></i>

21. I certify that I attended the deceased from <i>8-15-58</i> , 19 <i>58</i> , to <i>8-19</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>8-15-58</i> , and that death occurred at <i>8-19</i> M, from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) <i>Berlin, MD</i>					
DATE SIGNED <i></i>					

ACTUAL SIGNATURE <i>Orlando Schott</i>	M.D. <i></i>	22. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Aug. 23/58</i>			
PHYSICIAN'S NAME (Type) <i>CLIFFORD E. SCHOTT</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill</i>		22d. LOCATION (City, town, or county) <i>Newark</i>	(State) <i>MD</i>

23. FUNERAL DIRECTOR'S SIGNATURE <i>Clay & Dennis</i>	ADDRESS <i>Snow Hill, MD</i>	24a. REC'D. BY REGISTRAR DATE <i>AUG 20 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician an application for a burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, 3 to the funeral director. Page 4 should be forwarded to the Maryland Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, 3 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9661

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 1 Film G232 8-19-58 et

09655

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WORCESTER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN		c. LENGTH OF STAY IN 1b BERLIN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) (Own home)		d. STREET ADDRESS 1 WEST ST	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Cyrus	Middle WILLIAM	Last TAYLOR
4. DATE OF DEATH Month Aug.	Day 10	Year 1958	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 30, 1904
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 54 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC		10b. KIND OF BUSINESS OR INDUSTRY PROCESSING PLANT	
11. BIRTHPLACE (State or foreign country) BERLIN MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN TAYLOR		14. MOTHER'S MAIDEN NAME Mary BOSTON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-28-169	
17. INFORMANT Mrs. Cyrus Taylor, Berlin, MD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 976x		INTERVAL BETWEEN ONSET AND DEATH Penetrating Nervous, Ocular, D.S.W. Intraocular	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) into Pneumonia			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Suicide	
20c. TIME OF INJURY Month, Day, Year 9:00 a.m. 8/18/58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Berlin Worcester Md.	
(County) Baltimore Worcester Md.		(State) MD.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Herman A. Robbins	CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) Herman A. Robbins MD	DATE SIGNED 8/12/58		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/13/58	22c. NAME OF CEMETERY OR CREMATORIAL EVERGREEN	22d. LOCATION (City, town, or county) BERLIN
23. FUNERAL DIRECTOR'S SIGNATURE Anna A-Burbage Berlin Md		ADDRESS	24a. REC'D BY REGISTRAR DATE AUG 14 '58
			24b. REGISTRAR'S SIGNATURE Arthur S. Tracy

STATE OF CALIFORNIA
MEDICAL EXAMINER CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9662

CERTIFICATE OF DEATH

Reg. Dist. No.

09656

1. PLACE OF DEATH a. COUNTY Worcester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill		c. LENGTH OF STAY IN 1b All her life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 403 West Market St.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill	
3. NAME OF DECEASED (Type or print) Ada		d. STREET ADDRESS 403 West Market St.	
4. DATE OF DEATH 8		Month 8	Day 11
5. SEX Female		6. COLOR OR RACE AA	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 4-12-1905	
9. AGE (In years lost birthday) 53 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Canning	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Gillett		14. MOTHER'S MAIDEN NAME Matilda Spencer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Mrs. Ella Nelson, 403 Market St., Snow Hill, Md.	
17. INFORMANT Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia and Inanition 171X DUE TO Epidermoid Carcinoma of the Cervix 18 Mos Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-17-57 , 19, to 8-11-58 , 19, that I last saw the deceased alive on 8-11-58 , 19, and that death occurred at 12:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Dr. Robert La Mar ACTUAL SIGNATURE <i>Robert La Mar</i> M.D. DATE SIGNED 8/15/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-16-1958	
22c. NAME OF CEMETERY OR CREMATORIUM Mt. Wesley Cemetery		22d. LOCATION (City, town, or county) Nr. Snow Hill, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart Funeral Home, Salisbury, Md.		24a. REC'D BY REGISTRAR AUG 20 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be signed and for use as the burial-transit permit. Then please remove cover papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF HEALTH - DIVISION OF
CERTIFICATE OF DEATH

NAME OF DECEASED	AGE	SEX	CAUSE OF DEATH
EDWARD J. KELLY	50	MALE	HEART DISEASE
ADDRESS	AGE AT DEATH	TIME OF DEATH	TIME OF DEATH
1015 15th Street	50	10:00 P.M.	10:00 P.M.
Omaha, Nebraska	50	10:00 P.M.	10:00 P.M.
DEATH CERTIFICATE NUMBER	ISSUED BY	ISSUED ON	EXPIRES ON
100-12345678	OMAHA DEPT. OF HEALTH	1968	1970
INSTRUCTIONS: Fill in all spaces. Use ink. Sign below.			
Signature: EDWARD J. KELLY			